(b) Any hospital which seeks an adjustment to its rates must agree to an operational review at the discretion of the Department of Human Services.

1. A request for a rate review must be submitted by a hospital in writing to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Budget, Fiscal Affairs and Information Systems, CN 712, Mail Code #23, Trenton, New Jersey 08625-0712, within 20 days after publication of the rates by the Department of Human Services (DHS).

i. A hospital shall identify its rate review issues and submit supporting documentation in writing to the Division within 80 calendar days after publication of the rates by the DHS.

2. The Division will not approve an increase in a hospital's rates unless the hospital demonstrates that it would sustain a marginal loss in providing inpatient services to Medicaid recipients at the rates under appeal even if it were an economically and efficiently operated hospital. Marginal loss is the amount by which a hospital's rate year's Medicaid reimbursement for inpatient services is expected to fall short of the incremental costs, defined as the variable or additional out-of-pocket costs, that the hospital expects to incur providing inpatient hospital services to Medicaid patients during the rate year. These incremental costs are over and above the inpatient costs the hospitals would expect to incur during the rate year even if it did not provide services to Medicaid patients. Any hospital seeking a rate increase must demonstrate the cost it must incur in providing services to Medicaid beneficiaries and the extent to which it has taken all reasonable steps to contain or reduce the costs of providing inpatient hospital services. The hospital may be required at a minimum to submit to the Department of Human Services, the following information:

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i. Operational reviews;

ii. Efficiency studies and reports identifying opportunities for cost savings;

iii. Minutes of the meeting of the hospital's board of directors and board's finance committee;

iv. Reports of the Joint Commission on the Accreditation of Health Care Organizations;

v. Management letters;

vi. The hospital's strategic plans, long range plans, facilities plans and marketing plans;

vii. The hospital's annual report;

viii. Any analyses of the hospital's marginal cost in providing services to Medicaid or other categories of patients;

ix. Cost accounting documentation or reports pertaining to the hospital's cost incurred in treating Medicaid recipients or the comparative cost of treating Medicaid and other patients;

x. A copy of the hospital's most recent Medicare cost report with all supporting schedules;

xi. Contracts with other payors providing for negotiated rates or discounts from billed charges; and

xii. Evidence that the appealed rates jeopardize the long term financial viability of the hospital (that is, that the hospital sustaining a marginal loss in treating Medicaid beneficiaries) and that the hospital is necessary to provide access to care for Medicaid beneficiaries.

(c) The Division shall review the documentation and determine if an adjustment is warranted.

(d) The Division shall issue a written determination with an explanation as to each request for a rate adjustment. If a hospital is not satisfied with the Division's determination, they may request an administrative hearing pursuant to N.J.A.C. 10:49-10. If a hospital elects to request an administrative hearing, the request must be made within 20 calendar days from the date the Division's determination was received by the hospital. The Administrative Law Judge will review the reasonableness of the Division's reason for denying the requested rate adjustment based on the documentation that was presented to the Division. Additional evidence or documentation shall not be considered. The Director of the Division of Medical Assistance and Health Services shall thereafter issue the final agency decision either adopting, modifying or rejecting the Administrative Law Judge's initial Office of

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Administrative Law decision. Thereafter, review may be had in the Appellate Division.

SECTION 1 APPENDIX

1.1 DEFINITIONS

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

"Adjusted admissions" means inpatient admissions increased to reflect outpatient activity and is calculated by admissions multiplied by total gross revenue divided by inpatient gross revenue.

"Base year" means the year from which historical cost data are utilized to establish prospective reimbursement in the rate year.

"Current Cost Base" means the actual costs and revenue of the hospital as identified as the Financial Elements in the base reporting period for the purposes of rate Setting.

"Commission" means the Hospital Rate Setting Commission.

"Diagnosis Related Groups (DRGs)" means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications and consuming a similar amount of resources.

"Equalization Factor" means the factor that is calculated based on defined Labor Market Areas and multiplied by hospital costs to permit comparability between differing regional salary costs in setting statewide standard costs per case.

"Financial Elements" means the reasonable cost of items approved as reimbursable under Medicaid.

"Grouper" means the logic that assigns cases into the appropriate Diagnosis Related Groups in accordance with the clinical and statistical information supplied.

"Inliers" means inpatient cases who display common or typical patterns of resource use, are assigned to DRGs and have lengths of stay within the high and low trim points.

"Inlier Rate" means the payment rate paid to hospitals for Inlier patient stays.

"Labor Market Area" means counties and municipalities in the State that are grouped in accordance with similar labor costs.

"Neonate" means a newborn less than 29 days of age.

"Outliers" means patients who display atypical characteristics relative to other patients in a DRG and have lengths of stay either above or below the trim points.

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"Preliminary Cost Base" means the estimated revenue a hospital may collect based on an approved schedule of rates which includes DRG rate amounts and indirect costs not included in the all-inclusive rate. Those indirect costs will either be the dollar amount specified or the estimated amount determined by a specific percentage adjustment to the rate.

"Rate Year" means the year in which current reimbursement takes place.

"Special (Classification A) Hospital" means a hospital, licensed by the Department of Health and Senior Services as a special hospital, that is reimbursed under the Diagnosis Related Groups methodology.

"Trim points" means the high and low length of stay cutoff points assigned to each DRG.

"Uniform Bill-Patient Summary (UB-PS) (also referred to as the UB-82)" means a common billing and reporting form used by the hospital for each Medicaid inpatient.

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Refer to Section 5.14 (c) Attachment 4.19-A

APPENDIX 1.2 Reimbursement Methodology for Graduate Medical Education

A. Certain residency programs that do not involve direct patient care responsibilities are considered ancillary for purposes of direct patient care cost determination. Adjustments made for these programs will apply to all DRGs. Ancillary programs include:

1. Anatomic and Clinical Pathology
2. Blood Banking
3. Chemical Pathology
4. Dermatopathology
5. Forensic Pathology
6. Hematopathology
7. Neuropathology
8. Nuclear Medicine
9. Nuclear Radiology
10. Radiation Oncology
11. Radioisotopic Pathology
12. Radiology, Diagnostic
13. Radiology, Therapeutic

B. All DRGs will be assigned to one of four residency categories for purposes of calculating the direct costs associated with Graduate Medical Education. The assignments are as follows:

1. Medicine

(a) Included programs;

1. Internal Medicine
2. Allergy and Immunology
3. Cardiovascular Disease
4. Dermatology
5. Endocrinology and Metabolism
6. Flexible First Year/Transitional
7. Gastroenterology
8. Hematology and Oncology
9. Infectious Disease
10. Nephrology (Renal Disease)
11. Neurology
12. Physical Medicine and Rehabilitation
13. Preventive Medicine
14. Pulmonary Diseases (Medical Diseases of the Chest)
15. Rheumatology
16. Psychiatry
17. Child Psychiatry

(b) Included DRGs:

009-025, 027-029, 031-032, 034-035, 078-080, 082-090, 092-097, 099-102, 104, 106, 112, 115-118, 121-136, 138-145, 172-183, 188-189, 202-208, 240-248, 256, 271-273, 277-278, 283-284, 294-297, 299-301, 316-317, 395, 397-399, 403-404, 409-414, 416, 418-421, 423, 425-432, 447, 449-450, 452-455, 462-467, 473, 475, 701-702, 704-705, 707-708, 710-711, 713-714, 735-736, 743-751.

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II. Surgery
(a) Included Programs:
1. Anesthesiology
2. Neurological Surgery
3. General Surgery
4. Colon and Rectal Surgery (Proctology)
5. Dentistry
6. Emergency Medicine
7. Hand Surgery
8. Musculoskeletal Oncology
9. Ophthalmology
10. Oral/Maxillofacial Surgery
11. Orthopedic Sports Medicine
12. Orthopedic Surgery
13. Otolaryngology (Otorhinolaryngology/Orofacial Plastic Surgery)
14. Pediatric Orthopedic Surgery
15. Pediatric Surgery
16. Plastic Surgery
17. Thoracic Surgery
18. Urology
19. Vascular Surgery, General.

(b) Included DRGs:
001-002, 004-008, 036-047, 049-069, 071-073, 075-077, 103, 105, 107-111, 113-114, 119-120, 146-171, 185-187, 191-201, 209-239, 249-251, 253-254, 257-270, 274-276, 280-281, 285-293, 302-315, 318-321, 323-326, 328-329, 331-332, 334-342, 344-352, 392-394, 400-402, 406-408, 415, 424, 439-445, 456-461, 468, 471-472, 476-477, 730-734, 741-742.

III. Obstetrics/Gynecology
(a) Included Program:Obstetrics/Gynecology
(b) Included DRGs:353-384.

IV. Pediatrics
(a) Included Programs:
1. Pediatrics
2. Child Neurology
3. Neonatal-Perinatal Medicine
4. Pediatric-Cardiology
5. Pediatric Endocrinology
6. Pediatric Hematology/Oncology
7. Pediatric Nephrology.

(b) Included DRGs:
026, 030, 033, 048, 070, 074, 081, 091, 098, 137, 184, 190, 252, 255, 279, 282, 298, 322, 327, 330, 333, 343, 396, 405, 417, 422, 446, 448, 451, 600-700, 712, 737-740, 752.

V. Family Practice
(a) Applied to all DRGs.

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C. Methodology

1. Medical programs:

A medical residency regression equation is defined to consist of:

The dependent variable, defined as the ratio of actual cost per case, by DRG, for each hospital with a Medical teaching program and the Statewide average non-teaching cost per case, by DRG, for all hospitals without teaching programs;

The first independent variable defined as the number of internal medicine programs (one or zero) per 5,000 case-mix adjusted discharges (Case-mix adjusted discharges = the hospital's number of inlier cases by DRG times the Statewide average cost per case for discharges within the appropriate groupings divided by the Statewide cost per case for inlier discharges in all DRGs times the hospital's actual number of outlier discharges); the second independent variable defined as the number of other medical programs per 5,000 case-mix adjusted discharges.

The adjustment to the standard portion of the DRG rates will equal:

For hospitals with a Medical residency program including an Internal Medicine program, but with no Ancillary program: the slope of the first independent variable adjusted for the Y-intercept times the ratio of 5,000 to the actual number of case-mix adjusted discharges, plus the slope of the second independent variable times the number of other medical programs per 5,000 case-mix adjusted discharges.

For hospitals with a Medical residency program without an Internal Medicine program and without an Ancillary program: the Y-intercept plus the slope of the second independent variable times each program per 5,000 case-mix adjusted discharges.

For hospitals with a Medical residency program with an Internal Medicine program and with an Ancillary program: the slope of the first independent variable adjusted for the Y-intercept times the ratio of 5,000 to the actual number of case-mix adjusted discharges, plus the slope of the second independent variable times the number of other medical programs per 5,000 case-mix adjusted discharges.

LUS

The ratio between the costs per DRG adjusted for Medical, Surgical, OB/GYN, and Pediatric teaching for teaching hospitals with ancillary programs and the costs adjusted for Medical, Surgical, OB/GYN, and Pediatric teaching for teaching hospitals with no ancillary programs.

11. Surgical programs:

A surgical residency regression equation is defined to consist of:

The dependent variable, defined as the ratio of actual cost per case, by DRG, for each hospital with a Surgical teaching program and the Statewide average non-teaching cost per case, by DRG, for all hospitals without teaching programs;

The independent variable, defined as the number of programs per 5,000 case-mix adjusted discharges (Case-mix adjusted discharges = the hospital's number of inlier cases by DRG times the Statewide average cost per case for discharges within the appropriate groupings divided by the Statewide cost per case for inlier discharges in all DRGs times the hospital's actual number of outlier discharges).

The adjustment to the standard portion of the DRG rates will equal:

For hospitals with a Surgical residency program but with no Ancillary program: for the first program per 5,000 case-mix adjusted discharges the slope adjusted for the Y-intercept, and for additional programs the slope times each program per 5,000 case-mix adjusted discharges.

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For hospitals with a Surgical residency program and with an Ancillary program: for the first program per 5,000 case-mix adjusted discharges the slope adjusted for the Y-intercept, and the additional programs the slope times each program per 5,000 case-mix discharges;

PLUS

The ratio between the costs per DRG adjusted for Medical, Surgical, OB/GYN, and Pediatric teaching for teaching hospitals with ancillary programs and the costs adjusted for Medical, Surgical, OB/GYN, and Pediatric teaching for teaching hospitals with no ancillary programs.

III. Obstetrics/Gynecology and Pediatric Programs:

The adjustment to the standard portion of the DRG rates will equal:

For hospitals with Obstetric/Gynecology and Pediatric programs but without an Ancillary program: the ratio between the costs per DRG for hospitals with teaching programs and the costs for hospitals that have none, for Obstetrics/Gynecology and Pediatrics, respectively.

For hospitals with a Obstetric/Gynecology and Pediatric programs with an Ancillary program: the ratio between the costs per DRG for hospitals with teaching programs and the costs for hospitals that have none, for Obstetrics/Gynecology and Pediatrics, respectively;

PLUS

The ratio between the costs per DRG adjusted for Medical, Surgical, OB/GYN, and Pediatric teaching for teaching hospitals with ancillary programs and the costs adjusted for Medical, Surgical, OB/GYN, and Pediatric teaching for teaching hospitals with no ancillary programs.

IV. Other Adjustments

In order to maintain base year budget neutrality for all programs except Family Practice, the difference between actual costs of teaching hospitals and the predicted costs derived by application of the above formulae will be apportioned over the adjustments for each specialty area.

V. Family Practice

Hospitals with accredited Family Practice residency programs will have their rates increased by a Family Practice supplement calculated as follows:

A ratio consisting of the total number of Family Practice residents in the base year divided by the total number of residents in all accredited GME programs in the same year

times

The Statewide standard costs, adjusted for teaching, of all accredited teaching programs minus the non-teaching for all DRGs in teaching hospitals

divided by

The standard direct patient care costs of all DRGs in hospitals with a Family Practice program.

The standard portion of direct patient care rates for all DRGs of hospitals with an accredited Family Practice residency program will be multiplied by the Family Practice supplemental factor plus one.